		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045419

Facility Name: Mother Theresa Home

Address: 1270 Franciscan Drive (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: 630-257-5801 **Fax #** 630-257-3987

IDPA ID Number: 36-2548288001

Date of Initial License for Current Owners: 04/16/65

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Richard Truesdale **Telephone Number:** 630-243-2244

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Robert Coon
(Title) Executive Director/Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Mother Theresa Home
35881
Change of Ownership
July 1, 2000
June 30, 2001

Please note effective July 1, 2001, the ownership of Mother Theresa Home changed
The new ID numbers are as follows:

IDPH Facility ID number	0045435
IDPA ID number	35112441002

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	730	5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	219	338		557	8
9	SNF/PED					9
10	ICF	18,227	31,193		49,420	10
11	ICF/DD					11
12	SC		478		478	12
13	DD 16 OR LESS					13
14	TOTALS	18,446	32,009		50,455	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.16%

D. How many bed-hold days during this year were paid by Public Aid?
245 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Beauty Shop and meals for Franciscan Village residents

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/23/90

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: June 30 Fiscal Year: June 30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Mother Theresa Home # 0045419 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	766,800	101,421	25,870	894,091		894,091		894,091			1
2	Food Purchase		582,252		582,252		582,252	(529,577)	52,675			2
3	Housekeeping	224,942	44,342		269,284		269,284		269,284			3
4	Laundry			122,559	122,559		122,559		122,559			4
5	Heat and Other Utilities			206,381	206,381		206,381		206,381			5
6	Maintenance	105,438	20,817	35,257	161,512	3,620	165,132		165,132			6
7	Other (specify):*			37,528	37,528		37,528		37,528			7
8	**TOTAL General Services**	1,097,180	748,832	427,595	2,273,607	3,620	2,277,227	(529,577)	1,747,650			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	2,541,113	423,776	364,691	3,329,580	(302,138)	3,027,442		3,027,442			10
10a	Therapy	135,879	1,363		137,242		137,242		137,242			10a
11	Activities	124,499	10,686	6,615	141,800		141,800		141,800			11
12	Social Services	100,024	763		100,787		100,787		100,787			12
13	Nurse Aide Training											13
14	Program Transportation			7,525	7,525		7,525		7,525			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,901,515	436,588	386,831	3,724,934	(302,138)	3,422,796		3,422,796			16
	C. General Administration											
17	Administrative	129,878			129,878		129,878		129,878			17
18	Directors Fees											18
19	Professional Services			251,450	251,450		251,450	(79,300)	172,150			19
20	Dues, Fees, Subscriptions & Promotions			30,711	30,711		30,711	(1,392)	29,319			20
21	Clerical & General Office Expenses	48,845	7,892	20,161	76,898		76,898		76,898			21
22	Employee Benefits & Payroll Taxes			824,994	824,994		824,994		824,994			22
23	Inservice Training & Education			1,299	1,299		1,299		1,299			23
24	Travel and Seminar			3,787	3,787		3,787	(708)	3,079			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,792	76,792		76,792		76,792			26
27	Other (specify):*											27
28	**TOTAL General Administration**	178,723	7,892	1,209,194	1,395,809		1,395,809	(81,400)	1,314,409			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,177,418	1,193,312	2,023,620	7,394,350	(298,518)	7,095,832	(610,977)	6,484,855			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mother Theresa Home #0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			343,486	343,486	(8,293)	335,193		335,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			357,456	357,456		357,456	(29,385)	328,071			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			15,337	15,337		15,337		15,337			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			716,279	716,279	(8,293)	707,986	(29,385)	678,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					302,138	302,138		302,138			39
40	Barber and Beauty Shops	82,833	5,326		88,159	4,673	92,832	(62,062)	30,770			40
41	Coffee and Gift Shops	25,900	35,569		61,469		61,469	(56,632)	4,837			41
42	Provider Participation Fee			82,051	82,051		82,051		82,051			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	108,733	40,895	82,051	231,679	306,811	538,490	(118,694)	419,796			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,286,151	1,234,207	2,821,950	8,342,308		8,342,308	(759,056)	7,583,252			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Mother Theresa Home #0035881 07/01/00-06/30/01

Line 6	$3,620	depreciation of non-care asset (chevy truck) from line 30
Line 10	-$302,138	pharmacy to special cost center line 39
Line 30	-$8,293	depreciation of non-care assets to lines 6 & 40
Line 39	$302,138	pharmacy from line 10
Line 40	$4,673	depreciation of non-care asset (beauty shop) from line 30
	$0	

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(529,577)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(29,385)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(563)	24		19
20	Contributions	(145)	24		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(79,300)	19		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,392)	20		28
29	Other-Attach Schedule beautynon res/deli	(118,694)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (759,056)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (759,056)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	x		302,138	10	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 302,138		47

Mother Theresa Home

ID# 0045419

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	beauty rev for non residents	$ (62,062)	40	1
2	coffee & gift shop rev	(56,632)	41	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(118,694)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mother Theresa Home # 0045419 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(529,577)	0	0	0	0	0	0	0	0	0	0	(529,577)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(529,577)	0	0	0	0	0	0	0	0	0	0	(529,577)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(79,300)	0	0	0	0	0	0	0	0	0	0	(79,300)	19
20	Fees, Subscriptions & Promotions	(1,392)	0	0	0	0	0	0	0	0	0	0	(1,392)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(708)	0	0	0	0	0	0	0	0	0	0	(708)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(81,400)	0	0	0	0	0	0	0	0	0	0	(81,400)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(610,977)	0	0	0	0	0	0	0	0	0	0	(610,977)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Mother Theresa Home** **# 0045419** **Report Period Beginning:** **07/01/00** **Ending:** **06/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,385)	0	0	0	0	0	0	0	0	0	0	(29,385)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,385)	0	0	0	0	0	0	0	0	0	0	(29,385)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(62,062)	0	0	0	0	0	0	0	0	0	0	(62,062)	40
41	Coffee and Gift Shops	(56,632)	0	0	0	0	0	0	0	0	0	0	(56,632)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(118,694)	0	0	0	0	0	0	0	0	0	0	(118,694)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(759,056)	0	0	0	0	0	0	0	0	0	0	(759,056)	45

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mother Theresa Home	100	Addolorata Villa	Wheeling	Franciscan Village	Lemont	Retirement Commu
		St. Joseph Home	Chicago	Franciscan Sisters of Chicago		
		St. James Manor	Crete		Lemont	Religious Congregat
		Franciscan Home & Community Services	Crown Pt, IN	Franciscan Sisters of Chicago Service Corp		
		George Davis Manor	Layfayette, IN		Homewood	Corporate Managem
		St. Elizabeth's Health Center	Delphi, IN	Franciscan Communities Home Care		
		St. Clare Health Center	Otterbein, IN		Lemont	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Financial, Human Resource	$ 245,678	Franciscan Village	0.00%	$ 245,678	$	1
2	V		Marketing, Development						2
3	V		Mission Integration &						3
4	V		Volunteer Services						4
5	V	34	Land Lease	15,337	Franciscan Sisters of Chicago	0.00%	15,337		5
6	V	14	Recreation travel expenses	7,525	Franciscan Village	0.00%	7,525		6
7	V	10	Salary Stipend for Sr. Jean Therese	18,800	Franciscan Sisters of Chicago	0.00%	18,800		7
8	V	11	Salary Stipend for Pastoral Care	13,961	Franciscan Sisters of Chicago	0.00%	13,961		8
9	V	4	Laundry Services	122,559	Franciscan Sisters of Chicago	0.00%	122,559		9
10	V	5	Water/Sewer	23,938	Franciscan Sisters of Chicago	0.00%	23,938		10
11	V								11
12	V								12
13	V								13
14	Total			$ 447,798			$ 447,798	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		St. Mary's Healthcare Center	Lafayette, IN	Franciscan Home Care	Crown Pt., IN	Home Care
		Franciscan Healthcare Center	Louisville, KY	St. Anthony Hospice	Crown Pt., IN	Hospice
		Mt. Alverna Home	Peoria, OH	Madonna High School	Chicago	School
				Marian Village	Homer Township, IL	Retirement Community
				St. Jude House	Crown Pt., IN	Women's shelter

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	3 Cost Per General Ledger Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Differences/ Adjustments for Related Organization Costs (7 minus 6)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 24 of Schedule VI.

Sum_6

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

0 Page 6A
0 Page 6B
0 Page 6C
0 Page 6D
0 Page 6E
0 Page 6F
0 Page 6G
0 Page 6H
0 Page 6I

Facility Name & ID Number **#** **0045419** **Report Period Beginning:** **07/01/00** **Ending:** **06/30/01**

Board Member	Position	Address	Phone	Ownership in entity that conducted business with this nursing home
Sister Francis Clare Radke	Chair	14700 Main Street, Lemont, IL 60439	630-257-7777	NONE
Len Wychocki	Pres/CEO	1055 W. 175th St., Homewood, IL 60430	708-647-6982	NONE
Wally Gargarczyk	Director	1055 W. 175th St., Homewood, IL 60430	708-647-6982	NONE
Sr. M. Francine Labus	Director	14700 Main Street, Lemont, IL 60439	630-257-7777	NONE
Sr. Jean Marie Toriskie	Director	4055 w. Belmont Ave., Chicago, IL 60641	773-202-0310	NONE
Barry Cesafsky	Director	914 S. Bodin, Hinsdale, IL 60521	312-782-3113	NONE
Sr. Diane Marie Collins	Director	5650 Independence Apt 3E, Oak Forest, IL 60452	708-535-9293	NONE
Chester Labus	Treasurer	1055 W. 175th St., Homewood, IL 60430	708-647-6500	NONE
Tracy Citta	Secretary	1055 W. 175th St., Homewood, IL 60430	708-647-6500	NONE

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Franciscan Sisters of Chicago
Street Address: 14700 Main Street
City / State / Zip Code: Lemont, IL 60439
Phone Number: (630-257-7776
Fax Number: (630-257-7887

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	per pound	1		$ 122,559	$	1	$ 122,559	1
2	5	Water/Sewer	per gallon	1		23,938		1	23,938	2
3	10	Salary Stipend for Sr. Jean	annual salary	1		18,800	18,800	1	18,800	3
4	11	Salary Stipend for Pastoral Care	annual salary	1		13,961	13,961	1	13,961	4
5	34	Land Lease	per acre	1		15,337		1	15,337	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 194,595	$ 32,761		$ 194,595	25

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Franciscan Village
Street Address: 1270 Village Drive
City / State / Zip Code: Lemont, IL 60439
Phone Number: (630-257-3377
Fax Number: (630-257-3987

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Financial, Human Resource	Direct Cost	1		$ 245,678	$ 178,998	1	$ 245,678	1
2		Marketing, Development								2
3		Mission Integration &								3
4		Volunteer Services								4
5	14	Recreation Travel Expenses	Direct Cost	1		7,525		1	7,525	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,203	$ 178,998		$ 253,203	25

0 Page 8A
0 Page 8B
0 Page 8C
0 Page 8D
0 Page 8E
0 Page 8F
0 Page 8G
0 Page 8H
0 Page 8I

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Franciscan Village	x		New Construction	$37,697.00	07/01/90	$ 5,135,000	$ 4,315,244	07/01/21	8.0000	$ 357,456	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$37,697.00		$ 5,135,000	$ 4,315,244			$ 357,456	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,135,000	$ 4,315,244			$ 357,456	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mother Theresa Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045419

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,293 B. General Construction Type: Exterior Brick/Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Franciscan Village - a retirement community, consisting of: 50 Independent Living Coach Homes @ 48,000 square feet
150 Independent Living Apartments @ 143,094 square feet
30 Assisted Living Apartments @ 20,334 square feet

Our Lady of Victory Convent - Motherhouse of the Franciscan Sisters of Chicago
Franciscan Communities Home Care located inside Our Lady of Victory Convent

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Note" Mother Theresa Home does		1989	$ 293,706	1
2	not own the land - It is leased from FSC				2
3	TOTALS			$ 293,706	3

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1990	1989	$ 5,724,856	$ 202,437	30	$ 202,437	$	$ 2,312,447	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements, roads, treet, etc.			1990	262,081	9,066	20	9,066		103,453	9
10											10
11	Wall guards			1992	5,771	364	15	364		3,421	11
12	Dishwashing Rooms/Nurses Station			1993	129,233	15,562	10	15,562		120,028	12
13	Landscaping-shrubbery			1993	6,581	329	20	329		2,577	13
14	Dining Room/Activity Room expansions			1993	652,933	21,764	30	21,764		165,046	14
15	Wall covering - dining room			1994	522		5			522	15
16	Donor wall by chapel			1994	13,016	434	30	434		3,110	16
17	Patio fencing			1994	1,805	219	8	219		1,715	17
18	Kitchen tiles/shelving			1994	4,159	209	20	209		1,364	18
19	Kitchen remodeling			1995	116,616	4,248	various	4,248		25,389	19
20	Landscaping-shrubbery			1995	620	62	10	62		362	20
21	Parking lot extension			1995	16,400	820	20	820		4,783	21
22	Computer networking			1995	15,097	1,259	5	1,259		15,097	22
23	1st floor nurses station remodeling			1995	12,016	471	5	471		12,016	23
24	Signage (name plates, etc. throughout building)			1996	799	40	20	40		207	24
25	carpet - administrative office			1996	565	103	5	103		565	25
26	shades - 2nd floor dining room			1996	1,528	304	5	304		1,528	26
27	outdoor handrailing			1996	535	62	5	62		535	27
28	chapel ventilation			1996	27,393	2,739	10	2,739		13,924	28
29	wall covering - 2nd & 3rd floor dining rooms			1997	4,242	848	5	848		4,029	29
30	Electric door closers			1997	1,101	110	10	110		477	30
31	Dish room renovation			1997	15,850	1,585	10	1,585		6,340	31
32	Parking lot paving			1998	7,000	875	8	875		3,208	32
33	Food Service Hallway renovation			1998	4,654	665	7	665		1,995	33
34	Replacement doors			1998	1,920	267	15	267		527	34
35	Doors/Exit devices			1999	3,127	226	15	226		486	35
36				1999							36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet-Administration area 2nd floor	1999	$ 2,515	$ 545	5	$ 545	$	$ 1,174	37
38	Fire alarm door upgrades - required	1999	18,952	1,369	15	1,369		2,843	38
39	Replacement doors	2000	1,745	126	15	126		223	39
40	Floor tile & installation	2000	5,675	283	20	283		544	40
41	Keypad locks for doors	2000	3,361	422	5	422		868	41
42	Clinic Sink - wall mount	2000	763	76	10	76		127	42
43	Roof top air conditioner	2000	10,418	694	15	694		810	43
44	Elevator flooring	2000	1,909	636	3	636		636	44
45	Oak Veneer doors	2001	6,362	1,272	5	1,272		1,272	45
46	Dock Wall Repair	2001	2,500	500	5	500		500	46
47	Lobby Doors	2001	7,617	1,523	5	1,523		1,523	47
48	Oak Veneer doors	2001	2,709	542	5	542		542	48
49	Exit devices	2001	5,003	1,001	5	1,001		1,001	49
50	Tub & hygiene chair	2001	13,306	2,661	5	2,661		2,661	50
51	Magnetic door & keypad	2001	2,172	434	5	434		434	51
52	Boiler shell probe	2001	1,672	334	5	334		334	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,117,099	$ 277,486		$ 277,486	$	$ 2,820,643	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 817,319	$ 45,044	$ 45,044	$		$ 459,505	71
72	Current Year Purchases	55,411	10,234	10,234			10,234	72
73	Fully Depreciated Assets	106,119	2,429	2,429			106,119	73
74								74
75	TOTALS	$ 978,849	$ 57,707	$ 57,707	$		$ 575,858	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administration/Activities	1996 Chevrolet Lumina	1996	$ 15,050	$	$	$		$ 15,050	76
77										77
78										78
79										79
80	TOTALS			$ 15,050	$	$	$		$ 15,050	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,404,704	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 335,193	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 335,193	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,411,551	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Beauty Shop/Pastoral Care offices	$ 115,982	$ 3,866	$ 36,084	86
87	Beauty shop equipment	2,338	117	1,298	87
88	Chevy Truck	21,723	3,620	21,723	88
89	Adjustable Shampoo Sink	2,569	257	428	89
90	Beauty shop equipment	2,166	433	433	90
91	TOTALS	$ 144,778	$ 8,293	$ 59,966	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				302,138		302,138	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 302,138		$ 302,138	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Mother Theresa Home # 0045419 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 393,223	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,000)	1,651,566		3
4	Supply Inventory (priced at cost)	60,158		4
5	Short-Term Investments	40,399		5
6	Prepaid Insurance	14,757		6
7	Other Prepaid Expenses	254,592		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,414,695	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	260,104		12
13	Land	292,682		13
14	Buildings, at Historical Cost	7,181,872		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,074,928		16
17	Accumulated Depreciation (book methods)	(3,471,517)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,338,069	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,752,764	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,594,261	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	180,127		28
29	Short-Term Notes Payable	102,433		29
30	Accrued Salaries Payable	278,067		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,154,888	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,315,244		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,315,244	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,470,132	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,282,632	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,752,764	$	48

***(See instructions.)**

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,729,274	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,729,274	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(437,098)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **net change in unrealized gains on inv.**	(10,452)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (447,550)	17
	B. Transfers (Itemize):		
18	**contributions for specific programs**	908	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 908	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,282,632	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,439,359	1
2	Discounts and Allowances for all Levels	(1,307,455)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,131,904	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	56,632	12
13	Barber and Beauty Care	104,299	13
14	Non-Patient Meals	529,577	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 690,508	23
	D. Non-Operating Revenue		
24	Contributions	53,413	24
25	Interest and Other Investment Income***	29,385	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,798	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,905,210	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,273,607	31
32	Health Care	3,724,934	32
33	General Administration	1,395,809	33
	B. Capital Expense		
34	Ownership	716,279	34
	C. Ancillary Expense		
35	Special Cost Centers	149,628	35
36	Provider Participation Fee	82,051	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,342,308	40
41	**Income before Income Taxes (line 30 minus line 40)****	(437,098)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (437,098)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	656	780	$ 22,783	$ 29.21	1
2	Assistant Director of Nursing	4,371	5,017	106,873	21.30	2
3	Registered Nurses	16,779	18,454	394,493	21.38	3
4	Licensed Practical Nurses	23,579	25,277	462,518	18.30	4
5	Nurse Aides & Orderlies	130,352	139,305	1,405,510	10.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,860	7,565	88,756	11.73	8
9	Activity Director	785	1,040	14,703	14.14	9
10	Activity Assistants	13,340	14,342	109,796	7.66	10
11	Social Service Workers	4,954	5,354	100,024	18.68	11
12	Dietician	1,864	2,080	54,327	26.12	12
13	Food Service Supervisor	12,391	13,198	146,605	11.11	13
14	Head Cook	10,431	11,166	128,256	11.49	14
15	Cook Helpers/Assistants	55,003	57,480	463,512	8.06	15
16	Dishwashers					16
17	Maintenance Workers	6,406	6,406	105,438	16.46	17
18	Housekeepers	22,727	24,853	224,942	9.05	18
19	Laundry					19
20	Administrator	930	1,040	66,710	64.14	20
21	Assistant Administrator	1,792	1,906	63,168	33.14	21
22	Other Administrative	930	1,040	15,477	14.88	22
23	Office Manager					23
24	Clerical	4,068	4,218	33,368	7.91	24
25	Vocational Instruction	1,376	1,443	29,130	20.19	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,468	9,568	166,929	17.45	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty/Barber			82,833		33
34	TOTAL (lines 1 - 33)	328,062	351,532	$ 4,286,151 *	$ 12.19	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	96	8,000	9/3	36
37	Medical Records Consultant	48	2,380	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,825	10/3	39
40	Physical Therapy Consultant	104	5,644	10a/3	40
41	Occupational Therapy Consultant	72	3,932	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Medicare Consltnt	4	400	10/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	420	$ 24,181		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	648	$ 31,567	10/3	50
51	Licensed Practical Nurses	3,488	125,709	10/3	51
52	Nurse Aides	9,192	193,168	10/3	52
53	TOTAL (lines 50 - 52)	13,328	$ 350,444		53

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Kolaz	Exec Dir/Adm	0	$ 15,011
Sandra Juhl	Exec Dir/Adm	0	51,699
Jan Nass	Asst. Adm	0	63,168
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 129,878

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Franciscan Village	Financial Services	$ 93,890
Franciscan Village	Human Resource Srvs	46,100
Franciscan Village	Development Srvs	43,250
Franciscan Village	Marketing Srvs	36,050
Franciscan Village	Mission Integration Srvs	15,828
Franciscan Village	Volunteer Coord. Srvs	10,560
Hall, Render Killian	Legal Srvs	3,272
Ernst & Young	Accounting Srvs	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 251,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 156,268
Unemployment Compensation Insurance	29,061
FICA Taxes	328,990
Employee Health Insurance	245,122
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Contributions	51,682
Employee Physicals & holiday gifts	13,871
TOTAL (agree to Schedule V, line 22, col.8)	$ 824,994

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	9,829
Health Care Worker Background Check	1,936
(Indicate # of checks performed 176)	
Various Memberships & Periodicals	2,689
Bank fees	14,865
yellow page advertising	1,392
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,392)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,319

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage, meal costs, etc	1,805
travel/ent	563
gifts/charity	145
Seminar Expense	1,274
Entertainment Expense	(708)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,079

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mother Theresa Home # 0045419 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mother Theresa Home # 0045419 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? no

(2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 58,658 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 82,051
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? n/a Indicate the amount. $ n/a

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Ernst & Young, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not issued at this time

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.